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THE CHARACTERISTICS OF ASTHMA IN INFANCY*

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THIS STUDY is an attempt to determine the characteristic features of asthma when it occurs during the first two years of life. In spite of the fact that asthma begins very frequently during this period, and has a tendency to be serious, very little has been written about this disease in early life.

Asthma very frequently begins during the first two years of life. In analyzing 164 cases seen in private practice, 56 cases began their wheezing during this period. Eight years ago, Dr. Stanley Freedman and I reported on 101 cases of asthma in childhood¹ and of this group 29 had it before two. Adding the two groups together, there are 265 children of which 32 per cent had asthma before two years of age.

O'Keefe has reported a group of children in 22 per cent of which the asthma began before two years of age.² Chobot found that 29 per cent had this onset in his group.³ So it seems clear that from 20 per cent to 33 per cent of asthma in childhood begins before the age of two.

TABLE 1

FREQUENCY OF OCCURRENCE OF ASTHMA BEFORE TWO

Analysis of 265 Cases of Asthma in Childhood

Number whose Asthma began before two . . . 85 (32%)
Number whose Asthma began after two . . . 180 (68%)

Both of the groups, comprising in all 265 children, were studied to see what relationship there

* Presented before the Providence Medical Association, at Providence, November 3, 1947.

¹ Buffum, W. P., and Freedman, S. S. *The Relation of the Household Dusts to Asthma in Childhood*. RHODE ISLAND MEDICAL JOURNAL 22:42, March, 1939.

² O'Keefe, Edward S. *An Analysis of Three Hundred Cases of Asthma in Children*. New England Journal of Medicine 214:62, January 9, 1936.

³ Chobot, R. *Asthma in Children*. American J. Dis. Child. 45:25, January, 1933.

was between the age of onset and the severity of the symptoms. Of the 85 cases with onset before two years of age, 32 per cent were classified as severe, and of the 180 cases with onset after two years of age, 20 per cent were considered severe. This supports the theory that asthma beginning before the age of two, is more likely to be severe than that beginning in later childhood.

TABLE 2

RELATIONSHIP BETWEEN THE AGE OF ONSET AND THE SEVERITY OF ASTHMA

	Mild	Severe
Asthma beginning before two	56 (66%)	29 (34%)
Asthma beginning after two	143 (80%)	37 (20%)

Thirty-eight of these patients were seen before the age of two and their asthma studied at that time. Of these, seven were seasonal cases with their symptoms chiefly in some period of the warm weather. Fourteen were persistently wheezy with no evident seasonal variation, and among these were most of the more serious and difficult cases. Ten were wheezy only with colds, but none of the four cases with completely negative skin tests were in this group. Seven had wheezing in spells which were not obviously respiratory infections.

TABLE 3

INFANTS UNDER TWO YEARS WITH ASTHMA. CLASSIFICATION OF CASES BY SYMPTOMS

Wheezingly with colds.....	10
Seasonal wheezing	7
Persistent wheezing	14
Wheezing in spells (non-seasonal)	7

The allergic inheritance is very evident in these patients. Twenty-one had a family history of asthma or hay fever on either the paternal or the maternal side, and an additional five had such inheritance on both sides. Twelve had no such inheritance.

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Fifteen patients had eczema either present or had had it in the past. Only three had had colic or vomiting in early infancy. There were twenty-five boys and thirteen girls. Among the seven most severe cases, five were boys and two were girls.

It has been stated that skin tests are not worth doing on babies. I cannot agree with this, as it seems to me that the tests were of definite help in planning treatment. The accompanying table shows the first eighteen scratch tests on seventeen babies under one year of age with asthma. The relation of the skin tests to the clinical sensitivity in some of the cases will be shown later.

The most interesting and instructive cases were the seven of greatest severity. These patients, whose clinical sensitivities and skin tests are shown in tables 5, 6, 7, 8, 9, 10, and 11, were in five cases made wheezy by many different etiological agents, including inhalants, foods, and respiratory infections. Only those clinical sensitivities which were definitely demonstrated are mentioned. It seems evident that more sensitivities would have been recognized if a greater effort could have been made in studying the patients.

It is interesting to note that one of these babies was repeatedly relieved by sulfadiazine, and two others were completely relieved for long periods.

of time by treatment in the hospital with penicillin intramuscularly. This must have been due to the lessening of superimposed infection.

NOTES ON CASES

TABLE 5

J. B.

SCRATCH TESTS

Years of age	Eight months
Cat	†
Dust	†
Wheat	†
Egg	†
Aspergillus	†
Spinach	†
Potatoes	†

He was made more wheezy by playing in the living room, lying on the bed or sofa, and by eating egg, potato, spinach or wheat.

Results: After one year of treatment he was improved. After seven years he still has "occasional asthmatic attacks."

The patient began to snuffle and have noisy breathing at three weeks of age. At three months

TABLE 4
THE FIRST EIGHTEEN TESTS
ON ASTHMATIC BABIES UNDER ONE YEAR OF AGE

J. A.	+	Cat
S. B.		Dog
J. B.		Rabbit
D. B.		Horse
A. C.		Feather
R. C.		Orris
L. D.		Cotton
D. D.		Kapok
L. E.		Dust
S. H.		Grass
D. K.		Ragweed
D. L.		Wheat
V. N.		Milk
B. O.		Egg
E. S.		Aspergillus
G. S.		Alternaria
L. S.		Hormodendron
All negative	+	
All negative		

of age this was so pronounced that he was studied and pronounced a case of Thymic Stridor. X-ray treatment did not change the symptoms.

At six months of age he was obviously dyspnic and a diagnosis of asthma was made. After his room was cleaned up he was very much better. It was noticed that he wheezed when taken into the living room or when put on his mother's bed, and also ingestion of wheat, egg, spinach or potato made him wheezy. If he was kept in his own room or out of doors and if these foods were avoided he wheezed very little. In this case the skin tests and the known clinical sensitivities coincided very closely.

TABLE 6

A. C.

His asthma began at seven months. He was seen at eight months when he was wheezy most of the time.

SCRATCH TESTS

Year of age	9/12	1 year
Horse		†
Dust	†—	0
Ragweed	†—	0
Egg	+++	††
Feathers	0	†
Orris		†
Cottonseed		†—
Kapok		†—
Hormodendron		††
Beef	†	
Chicken	†—	
Rice		†
Peanut		††
Mustard		†††
Silk	†	
Pyrethrum		†
Human	†	

He was made more wheezy by colds, and was distinctly better without milk.

Results: He had moderate asthma frequently until over a year old. After treatment with Penicillin he had no asthma for three months, and now at 2 years of age has had very little wheezing for 6 months.

In this case, as shown in table 6, there were many positive tests. He was wheezy all the time with severe exacerbations. He was put on a program of avoidance and injections without much change except that he was better without milk.

He was put in the hospital three times, and the third time was given penicillin intramuscularly for a week. This relieved him completely and he has been almost entirely well for six months.

I believe that this baby was sensitive to many inhalants and foods although we could not demonstrate this. The great benefit from hospitaliza-

tion and penicillin seemed to be clearly due to the clearing up of superimposed infection.

TABLE 7

L. D.

Her asthma began at 7 months. She was seen at 8 months when she had been slightly wheezy for 3 weeks and in severe dyspnea for 3 days.

SCRATCH TESTS

Years of age	8/12	18/12	8	5	12
Cat	0		†	†	††
Dog	0		†	†	†††
Horse			†	0	†—
Feather			0	0	†—
Kapok					†††
House dust			0		
Timothy	†—		0	0	†—
Wheat			0	†—	0
Milk	††	††	0	0	†
Egg	††	††	0	0	†
Rice			0	††	††
Salmon			0	0	†
Tomato		0			†
Hickory					††

She was made wheezy by colds, milk, cat and the dust of her own house.

Results: She improved very slowly and now, at 23 years of age, has occasional slight wheezing when she has a cold.

This patient in infancy was a severe case. It was demonstrated that she was clinically sensitive to milk, cat, and the dust of her own house, and much of her trouble was obviously brought on by colds.

Her improvement on a program of avoidance and injections was very slow over a period of years. This delay seemed to be at least partly due to poor success in eliminating dog dander and other dusts, and in getting co-operation in dieting.

Her final improvement seems to be the natural one which frequently take place as these children reach maturity.

TABLE 8

C. F.

Her asthma began at 14 months. She was seen at 16 months when she had a persistent cough with occasional wheezing.

SCRATCH TESTS

Years of age	14/12	2	38/12
Cat	††		
Dog	†††		††
Horse	0		††
Feathers	0		†
Dusts	†		†
Grass	0		†
Egg	†††		††

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Aspergillus	†	†	
Beef	+++	+++	†
Chicken	++	0	0
Carrots	0	†	0
Lima Beans	0	0	†
Spinach	0	†	0
String Beans	0	†	0
Potato	†	†	†—
Corn	++	†	+++
Peanut	0	0	†
Pork	++	0	0
Almond		†	0
Mustard			++

She was made wheezy by cat as well as by tomato, peas, string beans, spinach and respiratory infections.

Results: She did badly until at 6 years of age. Penicillin was given. During the last 8 months she has had 2 courses of Penicillin and each time has been well for 4 months after.

This baby is a case where the tests and the clinical sensitivities were by no means the same. She was clinically sensitive to tomato and peas which gave entirely negative tests, to string beans and spinach which each gave a faintly positive test once only, and to cat which gave a good positive skin test.

Here infection played a very important part. Her greatest improvement was evidently from the two courses of penicillin in the hospital.

TABLE 9

J. M.

His asthma began at 23 months. He was seen then and his wheezing was almost continuous.

SCRATCH TESTS

Years of age	1	11/12	4	7	8	11	14	23
Grass	0	0	0	0	0	++	†	
Ragweed	0	0	†	++	†	†	0	
Dog	++	0	++	++	++	†	++	
Cat	0	++	†	++		0		
Horse		+++	++	++		0		
Rabbit	0	0	0					
Feathers	0	0	0		+	†		
Dust		++	++	++	†	†		
Egg	++	++	+++	+	++	0		
Orris	†	0	†	0	++	++		
Own pillow						0		
Spinach						†		
Potato		++						
Peas		++						

He was made wheezy by dog, dust of his own cellar, eggs, spinach and sweet potato.

Results: He improved slowly and now at 23 years of age has wheezed for only two days during the last year. As an infant he wheezed all the time with period of moderate severity. His early tests were significant in that he was definitely made wheezy by a dog, and by eating egg or spinach.

0 Treatment by avoidance and by injection accomplished very little at first, but he gradually improved and at six years of age could go to school most of the time, and now at twenty-three years of age he is practically well.

It seems probable that he was allergic to many things that we could not demonstrate.

TABLE 10

M. M.

His asthma began at 7 months. He was seen at 13 months when he was wheezing all the time with periods of severe dyspnea.

SCRATCH TESTS

Years of age	1	11/12	21/2	7
Horse	†—		++	†—
Feathers	†		0	†—
Orris	†—		0	0
Cottonseed	†		0	0
Dust	†		†	++
Ragweed	†—		++	+++
Wheat	++++		+++	++++
Egg	+++		†	
Alternaria	0		0	†
Beef	0		0	†
Potato	†		†	†
Rice	++		++	†
Cornmeal	†		†	†
Oats	++		++	†
Rye			0	†
Peanut		+++		0
Mustard				†

He was made more wheezy by house dust, ragweed, prunes, beef liver, orange, probably by wheat, and also by respiratory infections. Beginning in his third year he was worse in the ragweed season.

Results: He improved only slightly and still wheezes some every day at 10 years of age. Otherwise his health is fair. As an infant he wheezed all the time with exacerbations. Treatment was notably unsuccessful, due partly to very poor family co-operation. He was known to be clinically sensitive to house dust, ragweed and several foods.

TABLE 11

A. T.

His asthma began at 4 months, and became severe at 14 months when he was wheezy most of the time. He was seen at 22 months.

SCRATCH TESTS

Years of age	1	10/12	4
Horse	++++		++++
Feather	++++		††
Cotton		0	†—
Kapok		0	††
Dust		0	††
Grass		0	+++

Ragweed	0	†
Wheat	0	†
Milk	††	††
Egg	††††	†††
Alternaria	0	†—
Hormodendron	0	†—
Many foods	†	†

He was made more wheezy by respiratory infections. He was better without milk and better without orange juice. Beginning in his third year he was distinctly worse in the grass season.

Results: At 6 years of age he has had moderate attacks in the last year and has been a little wheezy occasionally between attacks.

As a baby he was a very severe asthmatic, coughing, snuffling, and wheezing all the time. He improved gradually and was better without orange juice and also better without milk. Beginning in his third spring he was definitely worse in June and early July, probably on account of grass pollen. Sulfadiazine has been useful at times.

On a program of avoidance and desensitization he has slowly improved. During the last year, at 6 years of age, he has had two moderate attacks of asthma and has wheezed a little several other times.

It is evident that in these severe cases there were many sensitivities. The sensitivities listed were those in which the allergen was shown by trial to produce wheezing. It is obvious that there were many others which were not so demonstrated, as it was often by accident or by error that the demonstration took place.

It seems probable that babies with asthma have in general many sensitivities which are not obvious in the milder cases. This would adequately explain the fact that we get only moderate improvement by eliminating one or more known causes.

The action of infections is important at this age. Whether the attack is induced by an infection or a non-bacterial allergen, it seems evident that the bronchial reaction is often increased and prolonged by superimposed infection. Two of the seven severe cases described, who were wheezing badly week after week, gained a long continued relief by the use of penicillin in the hospital.

Among the babies we find many serious cases. If not treated promptly, they often get rapidly worse and become the most severe cases of chronic asthma. They need very carefully study and prolonged and painstaking treatment.

DIAGNOSIS

There is a characteristic of asthma in infancy which often makes us slow in making the diagnosis. The wheezing, prolonged expiration and the musical rales, which are typical of asthma in later life, are often absent in infancy. Instead there is

a noisy breathing with only moderate dyspnea, and with the stethoscope nothing is heard but loud tracheal rales. This noisy breathing which does not seem to be typical of anything may lead us away from the diagnosis of asthma.

The diagnosis is made, partly by the demonstration of allergy by history, skin tests, and blood eosinophilia, and partly by ruling out other conditions which could cause dyspnea.

Among the 38 cases reviewed, two had been diagnosed thymic stridor and one hypertrophied adenoids, and undoubtedly these diagnoses were incorrect.

RESULTS OF TREATMENT

It is recognized that children with asthma do better than adults. In the Rhode Island Hospital allergy clinic, Dr. Freedman and I found that 61 per cent of these patients were either entirely relieved or nearly so, and that a total of 87 per cent were definitely helped.¹ This was true one year after admission, and the results were still better three years later.

Table 12 shows the results after one year of treatment of the babies under two years. The number of cases is so small that a statistical analysis is of limited value. However, the figure of only 43 per cent of the known cases, which were entirely or almost entirely relieved, is suggestive of the difficulty of treatment at this age. Most of the others however were definitely helped, and it must also be taken into consideration that without treatment some of these patients would surely have developed a much more serious type of asthma.

TABLE 12

Results of Treatment after One Year

Perfect	4
Almost perfect	9
Fair and poor	17
Not known	8

One patient died three years later. Her asthma became worse but the cause and circumstances of death are not known.

SUMMARY AND CONCLUSIONS

The purpose of this paper is to present the idea that each infant with asthma has many sensitivities both inhalant and food. This is readily demonstrable in most of the severe cases and seems to fit in with the course of the milder ones.

It seems probable that infection acts to increase the irritability of the bronchi, and thus initiates an attack in an individual who is already in an abnormal state due to his allergy. An infection may also be imposed on an already edematous bronchial mucus membrane and prolong an attack of asthma.

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The picture of the disease as shown by these records gives no evidence in favor of bacterial allergy as a sole cause of asthma in any one case.

The frequency, severity and certain other characteristics of asthma in infancy are briefly discussed.

DISCUSSION

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ASTHMA in childhood is a real challenge and deserves our best efforts, not only because of the great suffering it produces but also because of the large number of children afflicted. Dr. Robert Cooke of New York states in his 1947 text book on clinical allergy, that 3½% of the population has bronchial asthma. If the childhood population is 1/5 of the total, then we have in this state alone about 3,000 children who have asthma.

I would like to go back a few years and trace the history of this amazing new field in medicine as it ties with Dr. Buffum's work.

We all know that allergy was born at the end of the last century with the introduction of diphtheria antitoxin. The use of horse serum created a situation which has heretofore never been known to medicine, namely serum sickness and anaphylactic death. So urgent was the use of diphtheria antitoxin at that time that its continued administration could not be interrupted no matter what the consequences. As a result of this situation an extensive amount of studies was undertaken mostly by immunologists. These studies were confined to the nature of serum sickness and anaphylaxis in man and experimental anaphylaxis in animals and a large mount of fundamental knowledge was thus obtained.

From about 1915 on a new crop of investigators appeared. These investigators began the study of clinical allergy in real earnest. They are now referred to as pioneers. I would like to mention the names of some of these men: Cook, of the Presbyterian Hospital in New York; Rackemann of the Massachusetts General Hospital; Walzer of the Brooklyn Jewish Hospital; Rowe of California; Alexander of St. Louis; Feinberg of the University of Illinois; Vaughn of Richmond. These men studied, analyzed, classified and observed thousands of patients over many years and their conclusions and observations together with the experimental work mentioned above formed the backbone of today's knowledge.

Precisely in the same manner Dr. Buffum has analyzed and studied his cases. His conclusions are not only sound, they should be taken as guides in the evaluation of any one given case. Most impressive is his statement of the multiplicity of sensitivities, especially in the severe cases. The greater the effort, the greater the possibility of discovering new factors.

We must never minimize the importance of house dust and its component elements, bearing in mind always that it is the organic nitrogenous matter in the dust which provokes sensitization. At the same time we must not rely entirely on house dust for by so doing the opportunities for uncovering additional factors will be lost. It is the judicious selection of the most likely offenders and their proper management which will give the best results.

I think we should not be too hasty with the use of penicillin, unless there is present an infection which in itself indicates its use. Penicillin is a moderate sensitizer and one should not subject a child who has an allergic constitution to unnecessary sensitizing substances.

I would like to call your attention to the urgent need of additional institutional facilities for allergic children. Our regular hospital facilities do not answer that need. A child whose asthma can not be controlled at home may need a change of environment from a few days to a few weeks. As soon as that child goes to the hospital and receives the same medication which at home gave no relief he becomes asthma free in a most spectacular manner. At this time the hospital is no longer a good place for him. In fact he is so well that he is in the way. Often upon his arrival home his asthma promptly returns.

What these children need is a hospital annex or a community asthma home located preferably in a suburb away from the hospital excitement and resembling a convalescent home. The annex should be so constructed and so furnished as to contain

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COMMON SKIN DISEASES AND THEIR TREATMENT*

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A CAREFUL ANALYSIS of the dermatologic problems confronting the general practitioner will reveal that the overwhelming proportion fall into several distinct groups, all of which are easily diagnosed and quite amenable to treatment. It is my intention to analyze these groups and to discuss methods of diagnosis and therapy which are readily available to the general practitioner.

HISTORY AND EXAMINATION

It is generally agreed that a lengthy or detailed history is unnecessary when dealing with the common skin diseases. As a matter of fact, the history is frequently misleading for the patient is apt to place undue emphasis on irrelevant events. The skin is laid out before us very much as the pages of an open book, and we have merely to observe and interpret. The best and least time consuming method of procedure is to ask the patient a few leading questions (duration and location of the eruption), then conduct the examination, following which specific questions may be asked in order to clear up any obscure points remaining in the examiner's mind.

Unless the skin disorder is quite obvious at first glance it is of the greatest importance to examine the entire body. Many patients, either through ignorance or reticence, will fail to expose enough of their cutaneous envelope, as a result of which many important diagnosis are frequently overlooked. For example, it has been my experience that patients with scabies will often be unaware of the fact that their body shows lesions typical of that disease.

It is essential that the examination be performed in a room with good lighting, preferably in daylight. The roseola of secondary syphilis or the nits of pediculosis pubis are easily overlooked in the absence of proper lighting.

The following diseases or groups of diseases are

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those most frequently encountered by the general practitioner.

SCABIES

Scabies is without doubt the most frequently misdiagnosed common skin disease despite the fact that in the vast majority of cases the diagnosis is quite simple. The incidence of this disease has shown a marked increase in recent years since many soldiers, upon returning home, have infected their families. The diagnosis is generally overlooked because (1) the disease is not suspected and (2) not enough of the body is examined. A diagnosis of scabies is made, not on the type of lesion, but rather on the distribution of the eruption. The sites of predilection are the finger webs, flexor aspect of the wrists, anterior axillary folds, elbows, umbilicus, buttocks and penis. In women the nipples are frequently involved. Upon questioning one will generally elicit the information that the eruption is very itchy at night and that other members of the family are involved. With a little practice the acarus scabiei or its ova may be demonstrated microscopically by examining the roof of a fresh vesicle after mounting it on a slide and adding a drop of 10% NaOH.

Treatment. It is important that all affected members of the family be treated simultaneously in order to prevent subsequent cross-infection. The old time honored remedy of 10% sulphur ointment massaged into the entire body twice daily for 3 days is still effective even though it is rather messy and may produce a sulfur dermatitis. It has been my experience that a combination of 5% sulfur and 5% balsam peru in an ointment base is efficient and rarely irritates. During the past few years benzyl benzoate 25-33% in an emulsion has become quite popular in that it is a cleaner method of therapy and more rapid in its results. A double application of this preparation allowed to remain on the skin overnight is generally sufficient to eradicate the disease, but it is a wise safety measure to repeat this treatment 24 hours later. Following antiscabetic therapy all bedclothes and wearing apparel should be thoroughly washed or cleansed. Any residual skin irritation may be controlled by compound calamine lotion or cold cream with $\frac{1}{2}\%$ phenol.

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INFECTIONS

Impetigo contagiosa and its variants are among the most common skin diseases seen by the general practitioner. The typical eruption of impetigo will present no diagnostic difficulties. The primary flaccid superficial vesicle produced by this disease ruptures quickly and exudes considerable serum which dries to produce a thick, honey colored crust. Because of the superficial nature of the disease process healing is accomplished without the production of scars although temporary pigmentation is frequently observed. When the disease affects the lower extremities it shows a distinct tendency toward deeper invasion of the tissues and often heals with scar formation. This type of infection is known as ecthyma and is most often seen in children, the subjects of poor hygiene.

Although impetigo is generally an innocuous condition it must be treated carefully because of its contagiousness. Then, too, if the bearded area is involved there may be extension of the process into the follicles to produce either a folliculitis or a stubborn treatment-resistant sycosis vulgaris.

It is well to remember that impetigo of the scalp and neck is frequently associated with pediculosis capitis while a generalized impetigo is often due to an antecedent scabetic infection. In these cases the underlying parasitic disease must first be treated.

Treatment. The most essential step in the treatment of infections of the skin is the removal of the crusts. This can usually be accomplished by bathing with warm water or oil until the crusts are softened. Following this step a local antiseptic is applied, and one may choose from many of these agents. 5% ammoniated mercury ointment is one of the oldest and most popular antiseptic ointments. It should be applied lightly not only to the individual lesions but also to the normal skin immediately surrounding them in order to prevent auto-inoculation. The sulfonamide ointments are frequently used even though many investigators feel that there is a distinct danger in sensitizing the patient to the drug. Penicillin ointment (1000 u/gm.) is a very efficient remedy and will often produce a favorable result in a comparatively short period of time. Commercial tinctures such as metaphen, mercurochrome and merthiolate may likewise be employed. It must be remembered that if iodine has been used mercurials are contraindicated since their combination will produce a severe dermatitis.

In widespread impetiginous eruptions small doses of ultra violet are quite helpful. It is occasionally but rarely necessary to administer oral doses of sulfonamides or penicillin injections.

For sycosis vulgaris good results are frequently obtained through the use of Squibb's antiseptic ointment (Quinolor).

ACNE VULGARIS

This disease presents no diagnostic problem. It occurs chiefly in adolescents and is characterized by comedones, papules, and papulo-pustules superimposed on an oily skin. The face, chest and back are most often involved and there is frequently a concomitant, oily scale in the scalp. The treatment of this condition constitutes a challenge which should not be evaded by the physician. If patients with this disorder are dismissed lightly with a pat on the shoulder and the inaccurate prognostication that they will outgrow the disease the ultimate result is often a severe cosmetic defect in the form of pitted scarring together with a marked inferiority complex.

Treatment. There are few cases of acne vulgaris which cannot be helped considerably by means of proper general and local therapy. Dietary instructions should be given the patient and while the diet need not be rigid it should not contain chocolate, fried foods, and excessive amounts of carbohydrates. Constipation must be combatted and a moderate amount of outdoor exercise prescribed. Foci of infection should be searched for and eliminated. Secondary anemia, when present, should likewise be corrected. In the vast majority of cases it will be found that the acne patient enjoys perfect health and no general therapeutic measures are necessary. In these cases the greatest dependence is placed upon local therapy, the object of which is to produce a moderate degree of dryness in a skin which presents an overabundance of oil. The following routine is successful in most cases.

Before retiring the affected areas are washed thoroughly with soap and water.

After the skin is dried a sulfur shake lotion is applied (either Kummerfeld lotion or Lotio alba may be used for this purpose) and allowed to remain on the skin overnight, the remnants washed off the following morning. Unless the lotion produces uncomfortable dryness of the skin it is to be used each night. If the skin is not dried sufficiently the strength of the lotion may be increased by the addition of resorcin $\frac{1}{2}$ -3% and beta-naphthal $\frac{1}{8}$ -2%.

It is well to instruct the patient that comedones and pustular lesions should not be expressed unless only a minute amount of pressure is required. Undue squeezing and picking will aggravate this condition and will frequently lead to excessive scarring.

If an ultra violet lamp is available, suberythema doses once or twice weekly are frequently beneficial. The patient should be advised that at least three months of "drying treatment" are necessary. Should there not be noticeable improvement after that period of time a Dermatologist should be consulted. Superficial x-ray therapy in the hands

of the dermatologist often produces amazingly good results in even the most disfiguring and obstinate cases of acne vulgaris.

In passing, it has been found that injections of hormones, vaccines, penicillin and the sulfa drugs are of no avail in the therapy of acne vulgaris.

FUNGUS DISEASES

The mycotic diseases discussed in this paper will be limited to those of the superficial variety, which involve the feet, body and scalp.

DERMATOPHYTOSIS OF FEET

Dermatophytosis of the feet is seen so commonly in this country that most patients with a mild degree of involvement do not seek medical advice. Upon examination one may discern a slight amount of maceration and scaling between the toes, most commonly in the 4th interspace. When, because of increased perspiration and friction with attendant loss of local resistance on the part of the tissues, the process becomes more acute, the eruption presents a different picture. There will be vesiculation, exudation, crusting and edema—the cardinal signs of an acute eczematous eruption. A secondary allergic reaction known as a dermatophytid may appear about the fingers during this acute stage.

The diagnosis of dermatophytosis may be confirmed by examination of material from the eruption. Mycelial threads and occasionally spores may be demonstrated microscopically after the tissue is allowed to dissolve in 10% NaOH.

Treatment of ringworm of the feet is dependent on the stage of the eruption. If the process is acute, soaks of Burows solution, normal saline or boric acid should be used. If there is secondary infection soaks of 1:4000 potassium permanganate solution will prove very efficient in combatting the pustular element. After the acute process subsides, fungicidal and keratolytic agents may be employed. Whitfield's ointment ($\frac{1}{2}$ strength), 5% salicylic acid in alcohol or Castellani's paint are useful in the chronic stages. Of late, much attention has been devoted to the use of higher fatty acids and their salts. The great advantage of these newer preparations, (propionic and undecylenic acids), is that they may be employed in practically any stage of the condition without danger of producing a dermatitis.

TINEA CORPORIS

Of less common occurrence is fungus disease of the body. As a rule tinea circinata presents a well defined, annular eruption with vesicular margins and a distinct tendency to clear in the centre while extending peripherally. The diagnosis is confirmed by the microscopic demonstration of mycelial threads in tissue obtained by scraping the outer vesicular margin of the lesion. Treatment is not

difficult and consists of application of a keratolytic agent such as 5% salicylic acid ointment until the superficial epidermal layers have exfoliated, in this manner ridding the skin of the fungus elements.

Tinea versicolor presents a somewhat different picture. This form of fungus involvement produces no reaction on the part of the skin but merely layers itself as a thin film on its surface. Individuals with moist skins are usually subject to this condition and the covered areas of the body are affected to the greatest degree. The diagnosis is quickly established by the clinical appearance—light tan mottled areas which on close inspection appear to resemble thin cigarette paper plastered on the skin. A scraping will quickly reveal numerous mycelial and spore elements. Tinea versicolor may be cured through the local application of a saturated solution of sodium hyposulphite, but there is a distinct tendency toward recurrence especially during the warm seasons of the year.

TINEA CAPITIS

Tinea infection of the scalp has within recent years become a formidable problem in every large city. This condition affects children until the age of puberty when a natural immunity develops. This immunity may be explained on the basis of change in the oily scalp secretion with a resultant lowering of the PH. The disease is transmitted from person to person by body contact, exchange of caps, by unclean clippers in barber shops and by upholstered seat backs in moving picture houses.

The diagnosis of tinea capitis is made by the classic appearance of circular areas of partial alopecia in the scalp. The affected portion of the scalp may or may not show gross inflammation, depending upon the type of fungus responsible for the disease. Under Wood filter the areas invaded by tinea reveal themselves by the presence of brilliant green fluorescence. Examination of the affected hairs microscopically will reveal myriads of closely packed spores either around or within the hair shaft.

Tinea capitis is commonly produced by either human or animal type of fungus and the distinction in most cases may be made only by cultural characteristics. The differential diagnosis should be made, however, since the animal type will respond to local applications of 10% ammoniated mercury ointment or to the newer undecylenic and propionic acid fungicidal agents, while the human form will remain quite resistant to local therapy. The latter type will often require temporary epilation through the use of x-ray. Under this method of therapy local applications are used during the three month period during which the scalp is devoid of hair.

continued on next page

PITYRIASIS ROSEA

Pityriasis Rosea is a skin disease of unknown etiology which is most prone to occur in the Spring and the Fall. The process usually develops first with a solitary lesion on some portion of the trunk, (the so called herald plaque), followed one or two days later by a multitude of smaller lesions most pronounced about the thorax and abdomen. The individual lesion at the onset is pea to dime sized, slightly raised and erythematous, oval in contour, with its long axis parallel with the lines of cleavage in the skin. As the lesion grows older it becomes slightly larger and shows a tendency to scale in the center. Itching may or may not be a prominent symptom depending on the severity of the condition and the nervous threshold of the patient.

The full blown eruption may be confused only with secondary syphilis but as a rule the differential diagnosis is not difficult. It is undoubtedly a good safety measure for a serologic test to be performed in every case of suspected Pityriasis Rosea. Occasionally the primary or herald plaque may be confused with tinea corporis, but the absence of mycelial threads when the scraping is examined microscopically together with the subsequent appearance of a multitude of lesions will confirm the diagnosis.

The patient is to be reassured that the condition is not contagious, will leave no scars and will not recur. It is a self-limited condition, lasting about 6-10 weeks without therapy. However, if proper treatment is prescribed the course may be abbreviated to 10-14 days.

Treatment. Any method of therapy which produces a mild exfoliation of the epidermis is indicated. Generalized ultraviolet radiation in suberythema doses every second day is a clean and effective method of attaining this end. If itching is a prominent symptom calamine liniment with $\frac{1}{2}$ -1% phenol and $\frac{1}{4}$ - $\frac{1}{2}$ % menthol is helpful. 3% resorcin may be added to the mixture in order to promote exfoliation. It is best to limit the use of soap on the affected areas and in very severe cases colloid baths may be prescribed.

CONTACT DERMATITIS

Skin eruptions due to external contacts may be produced by substances of animal, mineral or vegetable origin. As a rule the diagnosis can be made rather readily on the basis of an inflammatory skin eruption characteristically involving the exposed areas of the body and composed of vesicles and bullae arising on an erythematous base. On the other hand the etiologic agent responsible for the outbreak may be determined only with great difficulty. It is often necessary to take a painstakingly accurate history, which will include the analysis of all contacts prior to the development of the eruption.

Dermatitis venenata due to plants usually presents an acute vesicular eruption arising primarily on the exposed portions of the body. One frequently observes a tendency toward linear arrangement of the vesicles. The commonest plant allergens are poison ivy, poison oak, and primrose.

Dermatitis due to cosmetics is diagnosed chiefly by the distribution of the eruption. Deodorants, lipstick and perfumes produce an eruption in sensitized individuals at the site of their application. Nail polish dermatitis, on the other hand, appears on the eyelids, cheeks and neck as erythematous, scaly, intensely pruritic, ill-defined patches. Dermatitis due to hair dye or lacquer first makes its appearance about the ears, eyelids, forehead and neck. As a rule the scalp is not involved because of its great natural resistance to chemical insult.

Dermatitis of occupational origin is of great importance because of its frequent occurrence and disabling tendency. The agents responsible for this type of eruption may be placed in two categories (1) Those which are primary irritants and will, therefore, produce an eruption in every individual (strong acids and alkalies) and (2) Those which will sensitize certain individuals following a primary exposure (oils, dyes). As a rule it is not difficult to ascertain the cause of the eruption when due to a primary irritant, but the reverse is true when the sensitizing agents are considered. In these cases the application of suspected substances to the skin by means of the patch test is of considerable importance. Since occupational dermatoses have been made compensable by appropriate legislation in many states it is important whenever possible, to determine the exact etiology in a dermatitis of that nature.

Treatment of Dermatitis. Removal of the offending agent is generally followed by rapid improvement of the eruption. Where cosmetic dermatitis is suspected all cosmetics should be removed until the causative allergen is found. When occupational dermatitis is diagnosed the patient, during his period of treatment, should either cease work entirely or change to another type of work, depending upon the severity of the eruption.

Therapy in all cases of dermatitis should be of the soothing variety. In the acute stage of the disease lukewarm soaks, compresses or saturations must be depended upon. Saturated solutions of boric acid, magnesium sulfate, and (1-30) Burrow's solution are most commonly used in this stage. When the process begins to dry a light application of cold cream or boric acid ointment will prevent painful fissuring and undue tightness of the skin. The patient should abstain from the use of soap on the affected areas, but a sulfonated oil may be employed for cleansing purposes when necessary in the chronic stages.

1 Prophylactic therapy for poison ivy dermatitis by means of rhus antigen injection or ingestion is occasionally of some benefit. During the acute severe attack of poison ivy or poison oak cautious injection of the antigen has been of some value in my hands.

Whenever possible in the case of occupational dermatitis, the patient's occupation should be changed, for desensitization to the allergen cannot be accomplished in the light of our present knowledge.

ALOPECIA AREATA

This common skin condition of unknown etiology may affect any hirsute region but is seen most commonly in the scalp where an asymptomatic patch of complete baldness is observed. As a rule it grows slowly larger as the hairs at its periphery loosen and fall. Other similar areas may appear elsewhere and because of the cosmetic appearance become a source of great embarrassment and concern. Occasionally, but fortunately rarely, the condition progresses to involve the entire body.

Although the cause of alopecia areata is unknown it is thought to be associated with nervous influences for it frequently follows a "nervous shock" and usually affects high strung individuals. The diagnosis is made readily by the normal, smooth appearance of the affected areas. Because of the lack of inflammation and scaling it may be differentiated from tinea capitis. Other points of differentiation are that tinea capitis does not affect adults and shows a green fluorescence under Wood filter.

The prognosis is generally good except in elderly individuals and in cases of total alopecia. The hair usually regrows after a period of several months.

Treatment. Since the condition is apparently of nervous origin, therapy should be directed to avoidance of stress and strain along with the procurement by the patient of more rest and relaxation. Local therapy should be of the stimulating nature. Application of phenol-alcohol to the area of alopecia along with an exposure to ultra violet once weekly will hasten the regrowth of hair. When ultra violet radiation is employed it is to be remembered that the scalp will readily tolerate five times the dose given to other areas of the body. During therapy, therefore, the forehead and neck must be protected against undue exposure.

CONCLUSIONS AND SUMMARY

If the general practitioner is to practice good dermatologic medicine a few important, basic principles must be followed.

1. A careful examination should be performed in a well lighted room, and the entire body examined when the diagnosis is not immediately obvious.

2. The physician should acquaint himself with a few simple remedies, learning what may be expected of them when they are properly used. He should not use unknown proprietary medication at the recommendation of a detail man, until the value of such medication is thoroughly established.

3. The patient should be instructed carefully concerning the use of medication, its method of application and removal.

4. Skin diseases should never be overtreated. If in doubt, soothing medication is never harmful while overzealous use of strong medicaments will often produce a disastrous reaction.

5. The overwhelming majority of skin diseases are not difficult to diagnose and will respond readily to therapeutic measures available to the general practitioner.

11 E. Chase Street

CHARACTERISTICS OF ASTHMA IN INFANCY

concluded from page 864

a minimum of organic dust. In such a place a child could regain his lost weight and there he could be relieved completely of his residual asthma. We often see children whose asthma could not be controlled at home, but who are promptly relieved upon transfer to Lakeside Preventorium. It seems that a change in residence interrupts the mechanics responsible for the continuation of a given attack.

The filtration units which some of our hospitals have are not satisfactory. They are noisy, the room temperature can not be controlled properly and every time the door is opened suction draws in atmospheric air from the corridors and adjacent rooms. The most logical method of treating the acute attack in a child when home treatment has failed is to hospitalize him for two or three days in a clean, quiet room followed by a longer period of residence in a convalescent annex or unit such as described above so that by the time he goes home, he will have a reasonable chance to remain symptom free at least for the time being.

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PSYCHOSES WITH TRICHINOSIS*

A Review of the Literature and the Report of a Case

WALTER E. CAMPBELL, M.D.

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TRICHINOSIS is a generalized systemic disease caused by the parasite *trichinella spiralis*. According to autopsy reports, about 20% of the adult population of this country have been infested by the parasite. However, only a portion of these have exhibited the disease clinically. The disease is divided into three stages:—(1) The stage of invasion, (2) the stage of migration, (3) the stage of encystment. The first stage, lasting two or three days is initiated by the passage of the larvae through the intestinal walls setting up a severe irritation, causing symptoms of nausea, vomiting and diarrhea, and in general resembles acute food poisoning. The second stage is characterized by the dissemination of the larvae throughout the body by way of the blood stream. Chiefly the striated muscles are invaded, but the heart and brain may also be affected. This is accompanied by fever and varied and protean symptoms. The third stage of encystment takes place when the larvae are encapsulated in the muscle tissues.

It is during the stage of migration that the central nervous system is involved. This is not as uncommon as is generally believed. Merritt and Rosenbaum¹ found that 10% of the cases diagnosed as trichinosis at Boston City Hospital exhibited some involvement of the nervous system. However, up until 1936 only thirteen cases of psychoses associated with trichinosis were reported in the literature. Merritt and Rosenbaum in 1936¹, Most and Abeles in 1937², and Evers in 1939³ reviewed these same thirteen cases and presented additional cases. A review of the English literature since 1936 has revealed only six additional cases of trichinosis with cerebral involvement.^{1,2,4,5,6} In two cases the reason for hospitalization was an acute psychosis and they were direct admissions to psychiatric hospitals. The mental picture exhibited by these patients is that of an organic psychosis of the toxic hallucinatory type. Neurolog-

ically headache, stiff neck, muscular weakness, diminished or absent reflexes, hemiplegia or paraplegia were noted commonly. The diagnosis of trichinosis was established by the history of pork ingestion, a typhoid like fever, eosinophilia, usually of a high grade, by the skin test and by biopsy of muscle.^{7,8,9,10} It was rare that all criteria were positive in any one case.

When this disease involves the nervous system it may simulate (1) Polyneuritis, (2) Acute anterior poliomyelitis, (3) Encephalomyelitis, (4) Meningitis, (5) Dermatomyositis, (6) Periarteritis nodosa. In trichinosis of the central nervous system the spinal fluid is usually normal, helping to rule out poliomyelitis, encephalitis, and meningitis. Polyneuritis may be ruled out by laboratory tests, as may be dermatomyositis. Periarteritis nodosa may be ruled out by skin tests and biopsy.

The pathological changes in the nervous system are those of a non-suppurative meningo-encephalitis caused by the presence of the larvae of *trichinella spiralis* in the brain, chiefly in the cortical and subcortical layers, and also by non-specific changes due to toxic products of the larvae and decomposed muscle tissue. The latter changes are looked upon as being more dangerous and more common.²

The prognosis in these cases is not good. In Merritt & Rosenbaum's series, six out of thirteen died and two had residual neurological damage.¹ In the six cases reported since 1936, there was a mortality of 50%. The treatment of this disease is largely symptomatic and resembles much the care of the typhoid fever patient.

Report of a Case

The patient, A. H., a thirty-year old white married male of English extraction was well up until August 29, 1947, when he became nauseated, was unable to eat and had a diarrhea that lasted for three days and required treatment with bismuth and paregoric. During the two weeks prior to the onset of his illness he had eaten in a restaurant in the lower waterfront district of Providence while his wife was in the hospital undergoing surgery. His diet consisted chiefly of meatballs and spaghetti. He recalled eating no pork or sausage.

* Presented at a meeting of the Rhode Island Society for Neurology and Psychiatry, at Providence, October 20, 1947.

Following the diarrhea he developed severe headache and stiff neck, and on September 2nd it was found that he had a fever of 102.8°. He then had generalized pains in the chest, and weakness of his left leg. He became progressively worse until September 9th, when he developed severe backache, felt more feverish and became mentally confused. He stood in one position staring straight ahead for periods up to one hour. He chewed paper and sticks about the house and voided on the floor.

He was admitted to the Contagious Service of Chapin Hospital on September 11, 1947, with a tentative diagnosis of poliomyelitis. Because of his confused, uncooperative behavior he was seen by the neuro-psychiatric department on September 12th and transferred to that department on September 13th. At that time he appeared well nourished and well developed. He was restless, agitated, confused, disoriented, had a rectal temperature of 102° and complained of vague pains in his leg and buttock muscles. He rubbed his nose and mouth continually and answered questions in an irrelevant, facetious manner. He was ataxic and limped on his left leg. He had a positive Romberg falling backward and to the left. Deep reflexes were diminished in the left arm and leg. The left abdominal reflex was absent. There were no sensory changes.

Laboratory data:—Spinal fluid examination on September 12th and 16th was normal. White blood count on September 12th was 25,000. Differential showed 45% eosinophils. Repeated blood counts showed a rise in the white blood count to 30,000 with 57% eosinophils on September 16th. This gradually fell to 11,000 with 27% eosinophils prior to discharge. Daily urine examinations were negative. The Widal test for typhoid and the test for undulant fever were negative. Four stool examinations for ova and parasites were negative. Stool cultures for typhoid were negative. Blood serology was negative. Blood culture was negative as were x-rays of the skull, chest, and left hip. A skin test for trichinosis was negative on September 12th, but strongly positive on September 19th and again on September 21st. Biopsy of the left gastrocnemius muscle was done on September 22nd and showed a generalized myositis with infiltration of eosinophils. No larvae were found in this section.

Course in Hospital:

He ran a spiking temperature, between 100°-102.8° falling to normal after one week. His face became thinner and lost a diffuse puffiness. His confusion gradually cleared so that after two weeks he was mentally clear, and correctly oriented,

but had no memory for his acute illness. At this time he developed pain and swelling of his right face and severe precordial pain which lasted two days. He steadily improved and on discharge, September 28th, his gait and reflexes were normal. He was seen on a follow-up examination on October 16th. He felt better but not well enough to work, complaining of being more tense, nervous and restless than he was before his illness. He complained of some difficulty in judging distances which bothered him in driving and climbing stairs. Neurological examination was negative except for some pain in his lower legs.

In this case, the history of diarrhea, the typhoid-like fever, the vague muscular pains, the high eosinophilia, the skin test initially negative and later becoming strongly positive,⁷⁻¹⁰ and a biopsy showing generalized myositis with infiltration of eosinophils lead to a diagnosis of trichinosis. According to Merritt & Rosenbaum¹, Augustine⁸ and Spink⁹, the above criteria are sufficient to make this diagnosis.

Nineteen cases of psychosis due to trichinosis involving the nervous system have been reported in the American and English literature. An additional case of psychosis associated with trichinosis with recovery is reported.

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Centennial Day

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IT'S YOUR LIBRARY

RECENT VISITORS to the Medical Library have no doubt been impressed by the fresh appearances resulting from improvements made in the building.

The auditorium has lost its previous drab and somewhat dingy aspect. Fresh decorations have livened up the walls. A new lighting system with modernistic features is especially striking. A new wiring arrangement now permits instantaneous shifts of lighting before and after lantern-slide projections or moving pictures. The lack of such an arrangement has been a frequent annoyance to our lecturers. In connection with this change the correction of the wiring system required very extensive ripping of the ceiling, which added to the expense of renovation.

New decorations in the reading room, the Miller room, the coat room, and, lavatory impress the visitor immediately upon entrance.

The entire arrangements of the reading room have been radically changed. The long heavy library table which occupied the center of the room for many years has been removed and shifted to the basement floor. The few small tables previously scattered along the walls are being replaced by larger tables of a size more suitable for real library study. These will have more satisfactory individual lighting for each table. The various book shelves and periodical stands are also

to be replaced by more practical fixtures. More comfortable chairs are also being provided.

The reading room will now be used more frequently for small medical meetings, as well as meetings of other communal groups which in the past have used the facilities of the main auditorium.

The stack-rooms of the library are yet to be repainted and will also undergo changes in wiring and lighting, partly for additional safety and partly for increased general efficiency.

In the recent past, extensive repairs have been made to the roof of the building. Renovations have also been made in the sidewalks outside.

All these improvements cost money. A considerable amount has already been spent, and the present program calls for further continued expenses in the near future, within the limitations of our budget. For a number of years very little money has been spent in such upkeep. In consequence, the expenses of putting the building into proper shape have been considerable when concentrated into a relatively brief period.

It must be remembered that the Library Building was not purchased by the Rhode Island Medical Society. It was a gracious and generous gift made to the Society by the medical profession of the State. The acceptance of such a gift entailed the responsibility of suitable upkeep and care. This is a gift which is to be handed down to

future generations of physicians, and necessitates a proper and suitable pride in ownership.

Not many State Medical Societies are blessed with such a beautiful, permanent home combined with a useful, substantial medical library.

The present expenses and the necessary continuing program for future upkeep of the building constitute an appreciable part of the enlarged budget of the Society, reflected in the increase of annual dues.

THE KENNEY CLINIC

The Internes' Alumni Association of the Memorial Hospital, Pawtucket, have revived a delightful and valuable function which they had been forced to discontinue because of the war.

For many years we had looked forward annually to a full day of high grade, well presented clinical material. The staff of the hospital gave the morning program and ably demonstrated the excellent work done there.

After this a bounteous and tasteful lunch was served. We can add with enthusiasm that the kitchen work maintained the high standard of the scientific procedures. This communal eating associated with medical meetings is not to be sneered at, particularly at buffets where one moves about and mingles with friends and acquaintances. Then in the afternoon a group from one of the large Eastern medical centers would put on a program, always well worth attending.

The dens ex machina of these scientific skirmishes was Dr. John F. Kenney, the Chief of the Medical Staff of the hospital. His wide acquaintance and his persuading ways as well as his discrimination resulted in a notable array of brilliant men to instruct us.

Now Dr. Kenney is no longer a staff member but is enjoying an otium cum dignitate. How one who feels his oats as much as John Kenney can lead such an easy life with grace and cheerfulness is beyond our comprehension. Perhaps his medical advisor's choice of a tonic has a bearing on it.

At any rate, the active staff held a meeting on October twenty-nine and again a delightfully varied program pleased us as we always have been pleased in the past. Most felicitously these meetings have been given the name of

The John F. Kenney
Annual Clinic of
The Memorial Hospital

Dr. Kenney was there and evidently enjoying himself hugely. This is a graceful recognition of Dr. Kenney's worth and services and we look forward to many more of these fine affairs with Dr. Kenney enjoying them while his younger associates do the work.

MEETING THE CHALLENGE

The first of January marks the start for the sale of contracts to provide prepaid surgical insurance under the Rhode Island Medical Society's program. With the springing of the barrier we shall not anticipate a wild scramble of insurance agents to claim the potential business. Nor shall we promise great things for our program. We know that it faces a difficult development, but we have the courage of our conviction, and a strong belief in the desire of people in general to protect their own welfare in a free and voluntary manner.

We are in an age of restlessness. There is an undercurrent throughout the world that favors placing many personal rights and privileges under political control to an extent never previously thought possible. All this in spite of the fact that nowhere in the world has political dominance over production and distribution improved the state of the people. America alone has demonstrated that the greatest good can come to a people that is completely free. Yet we here are faced with the same undercurrent that has devastated other countries. We are faced—and particularly those of us concerned with the health of the nation—with direct and indirect charges, with unfounded accusations, and with distorted statistics, all for the purpose of attracting the malcontents and their like to the fountain of political power where the citizen becomes a "subject," and the patient becomes a "case."

In the face of this restless undercurrent we have had the courage to launch a prepaid program the success of which hinges on the initiative and integrity of private enterprise. We see in the insurance industry an agent that has won the trust of the people of this country. We have lowered our indemnities for surgical service to be rendered to persons whose income falls within certain limits. We have assumed the responsibility to see that the insurance contracts meet the requirements of the public, and that their terms are carried out.

We are encouraged by the advance notice from many companies who will operate under our program. These companies rank among the leaders in the insurance field. They have pledged to utilize their resources to promote the principle of budgeting for catastrophic disabilities necessitating surgical procedures for restoration of health. We know the result of their work will not be apparent for a year at least. But we also know that we are building on sound ground—that we are extending medical care in a manner that the public can understand, and in which it has every reason to have complete confidence.

For the individual physician there are tasks, too. He should first become very familiar with the de-

continued on next page

tails of the program in order that he may answer inquiries from patients and friends clearly and intelligently. He should accept every opportunity to encourage the purchase of insurance contracts approved by the Rhode Island Medical Society. He must do all this knowing that the success of the program will not result in any financial reward; rather, it will be the performance of a duty to self, to the community, and to the perpetuation of the American system of personal rights and opportunity.

WE AND DOCTOR GET PAID

Physicians of the state are promising to participate in the proposed voluntary prepaid program of surgical insurance. The plan is similar to the Blue Cross. We pay monthly for service that we may need, and the doctor gets his money quickly and does not wait, or perhaps never gets paid.

The plan is working already in some states. There was a time when the medical fraternity was not sold on the plan. They feared socialization of medicine. That is a plan where a doctor is placed on a salary, and the patient takes the doctor which has been directed to serve this or that community.

But apparently the fear of such a plan has disappeared, as the patient may engage his own physician and the doctor is assured of his pay. So we all ought to be happy.

... Editorial, *Westerly Sun*, Tuesday, October 21, 1947

THE PATTERN IS DRAWN

It is with great interest that we in Rhode Island read the announcement in the Connecticut newspapers in mid-November that the Connecticut State Medical Society was to consider at its meeting this month the adoption of a surgical-obstetrical insurance plan similar to that already accepted here.

For years our neighbors have been working on studies of prepaid medical care plans, and with the insurance capitol of the world within their borders they have undoubtedly had opportunity to gain first hand information on the mechanics of a suc-

cessful prepaid system of budgeting the costs of medical care through insurance.

That Connecticut has deemed it advisable to follow in great measure the program evolved by our Surgical Study Committee is a tribute to the physicians here whose unselfish service for the Society and the public resulted in the outstanding report adopted by the House of Delegates in September.

The pattern is drawn. We may look for its use in other parts of the country in the coming months.

EIGHTH ANNUAL CONGRESS ON INDUSTRIAL HEALTH

The Council on Industrial Health will hold its Eighth Annual Congress on Industrial Health in the Cleveland Auditorium, Cleveland, on January 5 and 6, 1948. These dates immediately precede the Interim Session of the American Medical Association, which will be held in the Auditorium on January 7 and 8. General practitioners supply a large part of the medical services which workers receive through industry, and they are cordially invited to attend these industrial health sessions. The program of the Congress is being constructed with general practitioners in mind and will include discussions of first aid and emergency services in industry, physical examinations, administrative practices, applied physiology, aviation medicine, radiation medicine and practical expositions of occupational disease management, traumatic surgery and rehabilitation. Since full use of medical services in industry depends on support from management and the worker, the essential relationships will be discussed. Industry needs medicine as a practical ally and to promote human relations. The Industrial Health Congresses are intended to further these objectives.

JAMA 135:357 (Oct. 11), 1947

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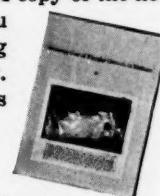
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THE MEDICAL STAFF AND THE HOSPITAL

GEORGE W. WATERMAN, M.D.

The following statement was made by Dr. George W. Waterman at the Annual Meeting of the Corporation of Rhode Island Hospital on November 12, 1947. Although the talk is directed to, and is concerned with the Corporation and Staff of this one hospital, it expresses so well the problems and ideals of all large hospitals that it is reprinted here.

The Editor

* * * * *

As PRESIDENT of the Staff Association of the Rhode Island Hospital, I am greatly pleased to respond to Mr. Gerry's invitation to address this meeting of the Corporation.

To my knowledge, this is the first time that a representative of the Medical Staff has been asked to take part in this exercise, this Annual Meeting. I believe that this invitation marks a new era in relationship between Corporation, Trustees, Administrative Staff and Medical Staff.

Your Trustees and administrators under the guidance of Mr. Gerry and Mr. Pratt have shown a growing interest and concern over the future of this hospital. They are naturally concerned over the expansion and development of its physical plant and of its essential service departments,—such as nursing, laboratories, etc.,—so necessary in arriving at the prime objective—"Good Patient Care". But beyond this they know and are fully aware of the necessity of providing the best possible medical staff, for without a well trained competent staff, excellent physical plant and services can avail but little in creating what they have in mind, a great medical center to serve the people of Providence and this vicinity.

In this day of rapid change and development of medical science, it is axiomatic that such a medical center as is envisioned must be staffed essentially with specialists in the different departments. The chiefs must be specialists, men of initiative and achievement who can carry on and direct research and educational programs and who are thorough masters of the techniques of their specialties. Younger men must be taught first as interns after their medical college requirements are fulfilled, and then as residents where they receive added experience, fitting them for examination by their specialty boards. Finally a place must be found for those best qualified to enter the hospital staff, where

they will rise in position according to their merit, to provide continuity of good patient care.

Staff Committees have for several years stressed the need of a program of research and education as a necessity in such a hospital as ours. You may quite naturally wonder why we must take on such a burden. Why can we not leave these functions to the medical schools? The answer is apparent to all good medical men. The spirit of inquiry into the causes and treatment of diseased persons is inherent in the medical mind. With the great amount of clinical material available here for study, the challenge to do something about it is great. To record, to compile statistics, to go on record in writing up case history and reports, to establish new facts, to improve on older established methods and procedures, and thus to contribute something, if only a small something to the sum total of all that is being done today towards the alleviation of human suffering and the prolongation of precious lives,—these are the really worthwhile things to medical men. This spirit of inquiry must be encouraged if we want good medicine.

Why must we have a program of education? Because in teaching others the principles and practice of medicine we educate ourselves. We need the contact of young developing minds. To answer the searching questions these young men ask disciplines our thinking, makes us want to be more sure of our grounds and careful in our judgments. The teaching instinct must be strong in us and we must have opportunity to use it if we would be good doctors.

Why must we have good staff organizations and staff relations? Because in such a highly specialized institution as yours is, there must be the closest integration between departments. We must know and respect each other as men who have a common cause, the best care for the sick person. We must consult when occasion arises, e.g., where complications arise during an illness, surgical, medical, etc., we must have the best opinion on the complication from the proper specialist with his special knowledge of such conditions. The internist may call on the special services of the biochemist or pathologist for blood studies and other laboratory procedures which aid in the diagnosis and treatment, on the X-Ray department or other service departments. In the medical center the patient has the best opin-

continued on page 880



which attends the shrinkage of swollen turbinates, the re-establishment of the patency of the upper respiratory airway and the opening of blocked ostia of accessory nasal sinuses with the resulting promotion of drainage.”*

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*Goodman, L., and Gilman, A.: The Pharmacological Basis of Therapeutics, New York, The Macmillan Company, 1941, p. 433.
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MEDICAL STAFF AND THE HOSPITAL

concluded from page 878

ion at a moment's notice from any department deemed essential to his care. The best Patient Care is no longer and cannot be a one man affair. It has become the responsibility of the whole closely integrated organization.

The programs of research, education, and good staff organization in a hospital of 500 beds are recognized as "musts" by the A.M.A. and the American College of Surgeons. In fact recognition of this hospital for the training of interns and residents is dependent on the established evidence of their presence.

We have recognitions for the training of interns. We have recognition of residencies in surgery, medicine, orthopedics and fractures, anesthesiology, cardiology, pediatrics, pathology, roentgenology and are in process of recognition in gynecology. We have already come a long way.

The medical staff at the Rhode Island Hospital has for many years rendered invaluable and excellent service in this community. Many brilliant and able men have played a part in its development. Its internship has been highly valued and has been the training ground for many men who have gone out and made a sure name for themselves, both nationally and locally. But we men of today cannot rest on past laurels. We have a big job ahead.

To say that everything is "just great" would be smug and unworthy of us, unworthy of any staff. We have a sound core. We are carefully studying weaknesses, learning to recognize them, and will correct them as the solutions become clear. Our aim is high. With all that we have at hand, all that we hope to get in better facilities with the opening of the new hospital, with the sympathetic understanding and help of our president, corporation and trustees and of our administrative staff, we shall create a medical staff worthy of the great medical center to which we all look forward, to which our citizens can look with pride and to which they can turn with sure confidence in their hour of need.

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THE EDUCATION OF THE NURSE

In the July issue of the RHODE ISLAND MEDICAL JOURNAL (Vol. XXX, No. 7) a discussion of the education of the nurse, offering some interesting observations on the nurse problem of today, was submitted by a member of the Rhode Island Medical Society who has a wide background in medical and nursing problems as they have existed in this State for many years. The Editors of the JOURNAL considered the communication a presentation worthy of general reading, and therefore published it with the name of the author withheld. In publishing the discussion neither the R. I. MEDICAL JOURNAL, nor the Society, endorsed the opinions of the writer of the communication. Therefore, the Editors willing devote space here for a reply from the Rhode Island State Committee on Nursing Education.

November 7, 1947

Editor
RHODE ISLAND MEDICAL JOURNAL
Rhode Island Medical Library
Francis Street
Providence, R. I.

Dear Doctor:

Enclosed is a copy of a reply to the article which appeared in the July issue of the RHODE ISLAND MEDICAL JOURNAL.

The State Committee on Nursing Education would very much appreciate your giving this reply consideration in as early an issue of the MEDICAL JOURNAL as possible.

Thank you for your consideration.

Very truly yours,
CECILIA E. WALSH, R.N., Secretary,
Nursing Education Committee

* * *

NURSING has news value at this time because of the ever increasing demand for nursing service. Because of this need many groups are beginning to share with the profession the great responsibilities involved in preparing young women for the care of the sick.

The Rhode Island State Committee on Nursing Education is vested by statute with the responsibility of "setting forth and maintaining standards for

schools of nursing, placing schools on the accredited list upon application and proof of qualifications and making such rules and regulations for the administration of the Chapter as will improve nursing education in the state". This group, therefore, was pleased to see an article appearing in the July issue of the RHODE ISLAND MEDICAL JOURNAL entitled "The Education of the Nurse" since it is logical that the medical profession should be interested in this phase of education.

It was a disappointment, however, upon reading the article to realize that it was written anonymously and that it contained assumptions which required clarification. The first of these assumptions is that professional nursing is opposed to the establishment of courses for the preparation of practical nurses. The profession has taken the initiative both nationally and locally in paving the way for the initiation of vocational training for women who will share in providing adequate care of the sick.

The Committee on Nursing Education in conjunction with nurses in the state have approached and encouraged the Rhode Island Director of Education to establish the vocational course for practical nurses which is being sponsored by the U. S. Office of Education. These plans are under advisement by the Director at the present time and we hope will shortly materialize. Even before this National program was available a local hospital requested permission to set up such a course under its auspices. The Committee on Nursing Education gave much help and professional advice to this hospital which conscientiously sought to meet its need for nursing service in this way. In spite of great plans and expenditure of funds there were no applicants for the course. It was obvious that part of the lack of applicants was due to the fact that Rhode Island has no statutory provision for the licensure of practical nurses. This provision was then incorporated as part of the Health Bill which for two successive legislative sessions has failed of passage. It appears that such legislation is a definite prerequisite for the establishment of any course for practical nurses and it is sincerely hoped that this Bill will receive favorable consideration by the next session.

Young women graduating from high schools to-
continued on page 884

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EDUCATION OF THE NURSE

concluded from page 882

day are rightfully searching for the professions which will provide the satisfaction and remuneration for which their qualifications entitle them. It is the school demanding the highest qualifications, not the least, to which these women are attracted. This is not only true in Rhode Island but all over the world.

Another assumption contained in the article referred to is that nurses are responsible for the fact that patients admitted to hospitals do not have sufficient people to care for them. The facts as stated by the Hospital Association are that hospital admissions have increased 100% within the past ten years. The number of graduate professional nurses has also increased but only by 13% which is a large increase when one considers the many opportunities open to young women these days, but is not sufficient to meet the service needs of hospitals.

The Committee on Nursing Education has based its criteria for evaluating the curriculum of schools of nursing in the state on the activities which nurses are required to perform. A recent spot check was made of the activities carried on by student and graduate nurses at the University of Rochester School of Nursing during a twenty-four hour period. These activities were performed on a general ward exclusive of the emergency wards, operating rooms and outpatient departments. The director of the nursing service reporting states that the checking was not intended to be exhaustive but to give some idea of what is expected of the nurse. The following are some of the items listed: Constant attendance upon patients in respirators; the giving of gavages; the placing of fifth leads for electrocardiograms, application of suction to surgical wounds, tracheotomies; chest cavities, and throats; the managing of apparatus for Wangensteen suction, tidal irrigation and bladder decom-

RHODE ISLAND MEDICAL JOURNAL

pression; irrigating eyes, cecostomies, colostomies; the giving of artificial respiration until respirator arrived and then starting the apparatus; using Danzer apparatus; the giving of insulin and teaching of patient to give the treatment; specialising patients after craniotomies, tracheotomies, and other surgery.

The director went on to say that all of these procedures were administered with no more direction by the doctor than the writing of the order. It is natural that he should expect that the nurses would be skilled and intelligent enough to carry out his orders and that when he returned he would find everything completed to his satisfaction.

The fact that the nurse on the ward does know these things is taken for granted now; but what would happen if all nursing of the sick were entrusted to women who only had as much preparation as that being advocated by the writer in his article?

Persons responsible for the education of nurses could take the easiest course at this time and succumb to the pressures which are advocating the turning over of nursing of the sick to a less well prepared group of women than exist today. In doing so, however, it recognizes that it would only be a short time before the resultant chaos would bring censure from the same group which now thinks that shortened courses are the only answer.

The Committee on Nursing Education, therefore, would welcome the opportunity of planning cooperatively with the Rhode Island Medical Society in meeting the nursing needs of the community of which we are all so keenly aware.

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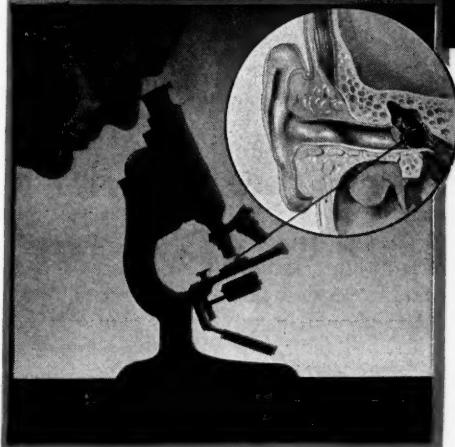
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the Microscope

Special Services The question of just where hospital services end and medical services begin has been a topic that many a physician has debated, especially since the Blue Cross hospitalization programs expanded through our communities. The Massachusetts Medical Society decided to do something about defining the terms. A committee headed by Dr. McKittrick of Boston, and comprising two members each from the Blue Shield, the Blue Cross, and the Massachusetts Hospital Association, the state Medical Society, and the specialties of radiology, pathology, and anesthesiology tackled the problem.

The committee came up with the definition of non-medical services as including administration, nursing, social service, record room and library, pharmacy, dietary service, housekeeping and laundry, maintenance of buildings, etc., provision of technical and non-technical personnel and their supervision, reports without interpretation from the clinical laboratories, and "such other services as may be necessary for the operation of a hospital.

The medical services were defined as "those services other than administrative rendered by a registered physician directly or indirectly to or in behalf of an individual patient for the obtaining and interpretation of data, including consultation and advice for the diagnosis, treatment and prevention of disease."

We note with interest that the committee also expressed the belief that (1) medical costs of hospital care should be separate from non-medical costs, (2) bills for all medical services should be rendered in the name of the physician performing the services, (3) that each part of the hospital be self-supporting in so far as possible, and (4) that fees for medical services collected by the hospital should be established by joint action of a representative committee of the staff and governing body of the hospital.

Toward Better Health The Research Council for Economic Security has recently released its latest publication giving

a survey of existing facilities and their potential development. The material is excellently presented. Notable observations include: (1) In answer to the question as to where existing plans for health protection fall short, attention is directed to the fact that it is not necessary, nor is it possible nor desirable that everyone in the United States should be reached by the same kinds of health program; (2) The means by which various programs can be expanded will not be the same, i.e. for some it is matter of money, others, education of the public, and for still others development of personnel; (3) health conditions vary from one location to another; (4) growth of any part of a health program is of most benefit when it is a balanced growth—going forward on all fronts at about the same rate; (5) The American people want better health, but nevertheless they are a practical people, interested in practical results, not dreams or theories.

One point seldom ever brought forward in health discussions was advanced by Dr. E. E. Vincent Askey, president-elect of the California Medical Association, who told the Conference on the Cooperation of the Physician in the School Health and Physical Education Program last October that "the public should be educated to expect some amount of illness as a normal outlook rather than to expect that good health is normal and that illness is something unusual." He added, too, that "children should be taught that sickness, accidents and disability are not an abnormal expectancy in life."

Mercy Cars The Worcester MEDICAL NEWS recently published an open letter to Governor Robert F. Bradford, and to Mayor Charles F. Jeff Sullivan, as well as the Mayors of all the cities in Massachusetts, calling to their attention the hazards on crowded highways caused by ambulances rushing in record breaking speed to hospitals. Citing the fact that the city of Providence limits the speed of ambulances and fire apparatus to 25 miles per hour, the NEWS

continued on page 888

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THROUGH THE MICROSCOPE

continued from page 886

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seconded the editorial statement in the *New England Journal of Medicine* that "racing over congested highways may shorten the length of time in getting to the hospital, but it is only occasionally that the minutes gained are of any benefit to the patient and may be truly harmful to one seriously injured." There is little doubt that more lives have been endangered, as the NEWS points out, by swiftly moving ambulances than have been saved by the hurried arrival at the hospital. But in our opinion the speed limit should not hold only in the congested areas, but throughout the state ambulances should respect the maximum travel speeds for all traffic. The siren and flashing light of an ambulance guarantees it a right of way that is willingly given, in our observation, by all motorists. The tragic death of the Woonsocket family group recently focuses attention on the need for consideration of this situation in Rhode Island.

County Society

Meetings

Why don't more physicians attend monthly meetings of their county medical society?

That question has undoubtedly puzzled many a county society president, and his program committee. The Philadelphia County Medical Society decided to take the question to its membership. A postcard questionnaire sought the information of each member (1) whether he attended meetings or not, and (2) what suggestions he could offer to improve programs and attendance. Replies from 500 members came back. Main reason for not attending: evening office hours make it difficult or impossible to get to early evening sessions. Other reasons advanced for absences: too busy; age; physical disabilities; distance, too many conflicting meetings; only interested in specialty meetings. Constructive suggestions included: more short, simple discussions of latest practical methods of diagnosis and treatment to keep general practitioner up-to-date; less information on etiology and pathology of rare and obscure diseases; more time and opportunity for discussion from the floor; more discussion of medical economics and public health problems.

*When Your Hair
Has Turned
to Silver*

The energetic Doctor Theodore G. Klumpp, newly-appointed head of the new Winthrop-Stearns pharmaceutical combine, had some worthwhile comments on the archaic system in this country of "pensioning off faithful retainers" solely on the basis of calendar age when he addressed the New Haven (Conn.) Medical Society at its annual meeting late in October. Warning of a severe economic dislocation

continued on page 890

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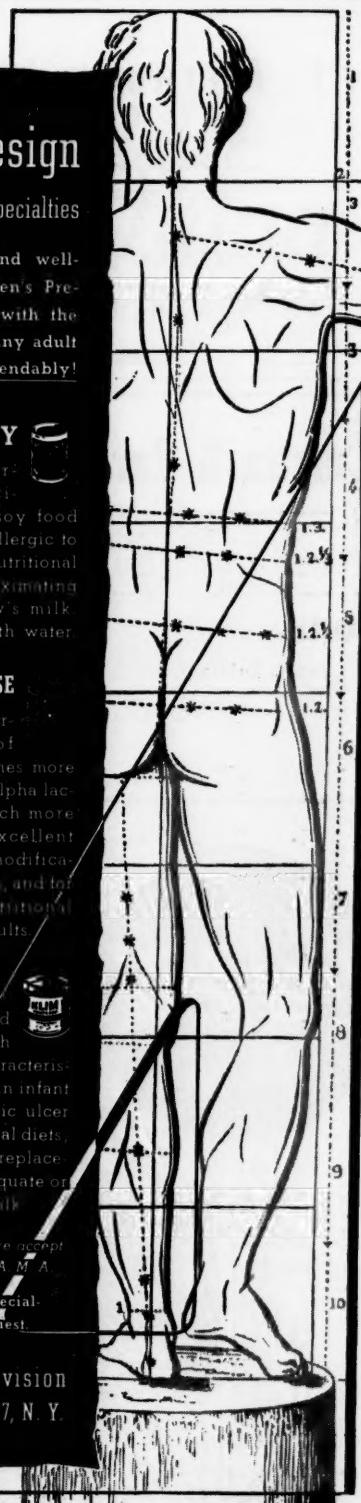
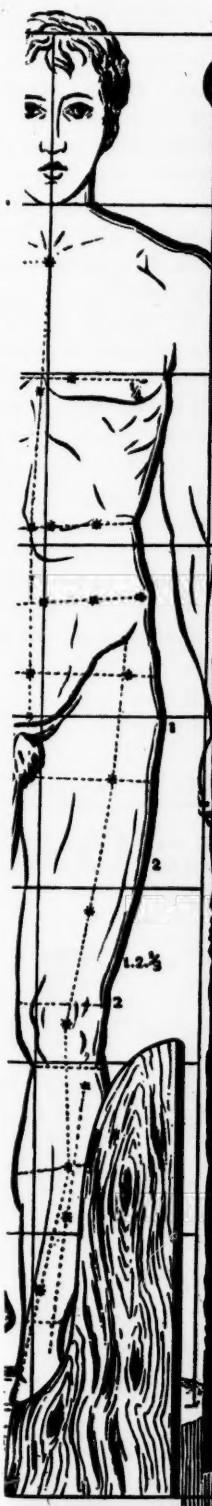
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THROUGH THE MICROSCOPE

*concluded from page 888***E. P. ANTHONY, INC.****Druggists**178 ANGELL STREET
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ahead if we persist in dumping workers in the "old age boneyard" when they reach a fixed age, Doctor Klumpp cited statistics of age groups to prove that by 1980 there would be potential labor surplus of 30 million workers if the elderly were scrapped summarily. Predicting a thirty-hour week in industry in a generation, he offered the following recommendations for adoption by federal, state, city governments and heads of industry: (1) abandon compulsory retirement on calendar age basis since physiological age is not the same as chronological age; (2) plan for retirement on a selective basis of fitness to do a given job; (3) base compulsory retirement on the recommendation of a retirement board composed of medical and psychiatric members as well as administrative officials; (4) offer opportunities for down grading in position and salary to the aging worker; (5) encourage industry, governmental and private institutions to make a greater effort to employ partially disabled persons; (6) change institutions for aged and disabled from asylums to modern institutions where every convenience and scientific development would be available for physical, mental and spiritual comfort.

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D14

VA HOME TOWN MEDICAL CARE PROGRAM

A summary of the highlights of the Conference on the Veterans Administration Home Town Medical Care Program sponsored by the Council on Medical Service of the American Medical Association, at Chicago, November 6, 1947.

THE MORNING SESSION of the Conference was devoted to presentations of the experiences of state medical associations with the V A program. Reports were made by Dr. Ralph H. Creighton for the North Central States; Mr. John Castellucci, director of the veterans care program administered in Michigan through Michigan Medical Service; Mr. Oliver Ebel, for the Kansas Medical Society; Dr. A. E. Larsen, medical director, California Physicians' service; and Mr. W. H. Tibbals of Utah, for the Rocky Mountain region.

Of the programs discussed that of Kansas was of particular interest to the Rhode Island delegation in view of the fact that it is a plan under the medical society supervision, and not under a medical care plan administration.

In Kansas the county medical societies grade the specialists in their district. Veterans filing pension claims are handled by the regional VA at its facility when possible, and otherwise are sent to physicians on the approved list according to the specialty, and on a rotating basis to provide equal distribution of the work among the doctors.

Under the program the VA notifies the veteran claimant to report for a physical examination. The executive office of the state medical society also receives a copy of the order. The completed examination report in turn goes to the medical examiner-coordinator at Topeka who checks on the report before it goes to the rating board. The State Society's cooperating committee meets weekly to check forms not properly made out. Forms in the latter category are returned to the physician for correction, and then come back to the medical co-ordinator, and thence to the rating board. The Committee averages a weekly check of 90 forms, and of this number about 15, on an average, are returned for correction.

DOCTOR HAWLEY COMMENTS ON PROGRAM

DOCTOR PAUL R. HAWLEY, chief medical officer of the Veterans Administration addressed the Conference in the afternoon session, highlighting the position of the VA in its relations with the medical profession, and the various medical so-

When the Kansas plan was initiated the executive secretary of the state society and the medical co-ordinator of the VA visited each county society to inform the members fully regarding the plan. As a result the experience in the past year has been most favorable.

* * *

Severe criticism of the Home Town Care program as operating in the Rocky Mountain area was submitted by Mr. W. H. Tibbals, executive officer of the Utah Medical Society. He read a letter from the presidents of the medical societies in the Rocky Mountain area sent to the administrator of the Veterans Administration protesting the setting of a maximum fee schedule in Washington, D. C., for the entire country.

Second major criticism of the Rocky Mountain group was that physicians in the rural areas state that if the VA continues to expand its program whereby it handles patients through its own staff in its own facilities, then physicians and small hospitals in rural areas will suffer a severe economic loss by reason of the assigning of patients to the VA clinics. The abuse of the VA medical privileges whereby veterans are given care for non-service connected disabilities was also cited.

* * *

Dr. Bauckus, speaking from the floor, reported that in New York state the co-ordinator system was being used with the medical co-ordinator in the employ of the medical service corporation of New York which works closely with the VA in handling the veterans medical problems. He noted that in the past six months there has been a restricting of free choice, giving as examples that surgery is free choice only in an emergency, and that after January 1 there will be no allowance for neuro-psychiatry by private physicians in New York city.

cieties, in the handling of the medical care of the veterans.

As the program interests the general practitioner, he stated, two views have been widely expressed, (1), that the private practitioner should

have no part in the program, leaving it entirely to the VA staff, and (2) that the VA should get out of the field and leave the medical care to the private physician.

Answering these two criticism Doctor Hawley pointed out that it would be impossible to build a VA staff big enough to handle the patient load, and therefore proposal 1, as above, must be opposed. As for the second criticism, he claimed that it would be impracticable, if not impossible, to leave the outpatient medical care of the veteran to the private physician. His reasons were several. They included: (1) Some kind of administration is necessary, and with the expenditure of government money there must be authorization by a responsible agency; (2) to administer the medical program a sizable medical staff is an absolute necessity, for the experience of the past two years has indicated that it is almost impossible to get 100% reporting on pension claims from private physicians; (3) adjudication of claims is by lay boards who require interpretations of the medical findings regarding various disabilities, hence it is necessary that the VA maintain a medical service trained in handling claims for pensions.

In answer to the criticism from various parts of the country that the private practitioner was not seeing the veteran because the VA was establishing outpatient clinics (similar to the setup in Rhode Island at the old Hope high school), Doctor Hawley stated that the VA is forced by law to maintain these clinics, and must keep the personnel attached to them busy. However, he claimed that the VA has no intention of expanding the outpatient facilities of its own. He reported that in 1941 there were 51 regional office outpatient clinics for four million veterans, and in 1947 there were 70 regional office clinics for eighteen million veterans; hence the expansion has not been proportional to the possible patient claim load. However, he did state that the VA now has 1,300 full time physicians on duty in outpatient clinics.

As evidence that the private practitioner would continue to be the key person in the medical care of the veteran, Dr. Hawley related that by next June 30 it is anticipated that 858,000 examinations will be done by private physicians, and by June, 1949, the annual total will be close to one and a half million.

In reply to the charges from the Rocky Mountain region (see above) that the VA was trying to adopt a national fee schedule, Dr. Hawley stated that no such purpose was intended. He did admit that a letter sent out from national headquarters was badly worded, and it gave a false idea of the reason for the schedule drafted at the Washington office. Turning on his critics he expressed the personal opinion that he was not certain that it was any great crime if the VA announced fees

provided it is clearly understood that the physician can accept the fee or not, or can accept the patient or not. The VA schedule, he stated, resulted from a study made by a group representing all the specialties, and it provided a fair average for charges to be used as a guide only and subject to local community conditions.

Among questions directed at the VA medical director in the open forum after his presentation was what the VA is doing to cut down the use of the medical care program by veterans with non-service connected disabilities. The answer was that when there is a vacant bed the VA will admit a patient with a non-service connected disability, by reason of Congressional action directing such procedure. In the fiscal year ending in June some 23 million dollars was spent for care on non-service connected cases, and the figure is expected to be close to 40 dollars for the fiscal year ending next June. Meanwhile, 60% of the hospital service is reported to be for care of non-service connected cases.

Hospital staffing will continue as already planned, with the local profession furnishing part-time service as staff members and as consultants. Selections for appointments will be on the basis of qualifications set up by Dean's committees where medical schools exist, and otherwise, as in the case of Rhode Island, by the state medical society.

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DISTRICT SOCIETY MEETINGS

PROVIDENCE MEDICAL ASSOCIATION

A regular meeting of the Providence Medical Association was held at the Medical Library on Monday, November 3, 1947. The meeting was called to order by the president, Dr. Guy W. Wells at 8:35 p.m.

The minutes of the previous meeting were read by the secretary and were accepted without any corrections.

Dr. Philip Batchelder, chairman of the Centennial Celebration Committee, reported briefly on the progress towards the plans for the 100-year observance of the Providence Medical Association. He stated that the observance would be centered in the last week in January of 1948 and would be climaxed with a dinner for the members and their guests at the Biltmore Hotel on Saturday, January 31, 1948.

Dr. Wells stated that at the previous meeting of the Association the surgical insurance plan of the state Medical Society had been unanimously endorsed. He stated also that each of the district medical societies in the state had taken the same action. However, he noted that many Providence physicians have not as yet signed the physicians participating agreement and he urged them to do so.

Dr. Wells reported that he had named a Committee consisting of Dr. Herbert Partridge and Dr. Pearl Williams to prepare the Association's tribute to the late Dr. Jay Perkins.

Dr. B. Earl Clarke, member of the Cancer Committee of the state Medical Society, spoke briefly

relative to the benefit football game, the proceeds from which to be turned over to the Rhode Island chapter of the Cancer Society to further its work. He stated that tickets would be available for purchase from him immediately after the meeting of the Association.

Dr. Wells introduced for the first speaker of the evening Dr. William P. Buffum, Chief, Pediatric Service, Rhode Island Hospital, who spoke on "THE CHARACTERISTICS OF ASTHMA IN INFANCY". Dr. Buffum stated that asthma occurring before the age of two is not uncommon. In 32 per cent of 265 cases, the asthma began before the age of two. These cases are more severe than those beginning after two. Twice as many boys as girls have asthma.

He then showed case records of babies with asthma, their skin reactions and treatment results. Striking improvements in these cases were obtained by avoidance, desensitization, and penicillin.

Children usually show reaction to many things. The main point Dr. Buffum made was that if the children are treated for the major two to three things they are sensitive to, they are made comfortably better, although they still have some asthma, showing they are sensitive in some degree to many other things.

The discussant of the paper was Dr. Stanley Freedman, Associate Physician, Rhode Island Hospital.

The "PATHOLOGY OF ALLERGIC REACTION TO SULFONAMIDES IN A CHILD" was presented by Drs. Melbourne Burnett, Resident in Pathology, Rhode Island Hospital, and Robert J. Williams, Associate Pathologist, Rhode Island Hospital.

Dr. Burnett stated that as a rule tissue reactions are not specific, in most cases, reactions are generalized in all organs of the body. The sulfonamids, however, give specific reactions.

He presented a case of a child that had intravenous sulfadiazine and died 60 hours later.

Autopsy revealed areas of necrosis and parenchymal hemorrhages. Myocardial infarction, acute splenitis myositis, generalized lymphadenitis nephritis and nephrosis were found.

These pathological changes have only recently been recognized.

continued on page 896

DOCTOR CHASE HONORED

At the conclusion of the annual conference of medical society secretaries and state medical journal editors held at the American Medical Association headquarters last month Dr. Peter Pineo Chase, editor-in-chief of the RHODE ISLAND MEDICAL JOURNAL was one of five named to plan the program for the 1948 conference.

Named to serve with Dr. Chase were Dr. Dwight L. Wilbur of California, Dr. Philip E. Blackerby of Kentucky, Dr. Earl Whedon of Wyoming, and Mr. Charles H. Crownhart of Wisconsin.



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1. Lennox, W. G. (1947), Tridione in the Treatment of Epilepsy, *J. Amer. Med. Assn.*, 134:138, May
 10. 2. DeJong, R. N. (1946), Further Observations on the Use of Tridione in the Control of Psychomotor Attacks, *Am. J. Psychiat.*, 103:162, Sept.

DISTRICT SOCIETY MEETINGS *concluded from page 894*

Dr. Williams in the discussion did not believe the pathology in this case was similar to endarteritis nodosa.

The meeting was adjourned at 10:20 p.m.

Attendance 92

Collation was served

Respectfully submitted,

DANIEL V. TROPPOLI, M.D.
Secretary

BRISTOL COUNTY

A meeting of the Bristol County Medical Association was held Tuesday, October 21, 1947. The meeting was called to order at 9:15 p.m. at the Warren District Nursing Association with Dr. Marcus Merchant presiding. Those present included Doctors Bruno, Bray, Creamer, Drew, Dunbar, Forget, Giura, Holdsworth, Lewis, Merchant, Millard, Petrucci and Clark.

Minutes of the last meeting were read and approved.

The application of Dr. Charles W. Dunbar of 10 Appian Way, West Barrington, for membership in the Bristol County Medical Association was received, and Dr. Dunbar was unanimously elected to membership.

It was agreed that various individuals were to be responsible to make arrangements for meetings for the rest of the year.

Associate members would be assessed dues of \$5.00 per annum, with the exception of Dr. Bernardo who was elected to honorary membership of the Society without dues. It was agreed that dues for regular members would be \$12.00 per annum.

Dr. Francesco Ronchese, of Providence, introduced by Dr. Merchant, gave an instructive talk, illustrated with lantern slides, on common dermatological conditions.

The rest of the evening was devoted to a discussion, led by Dr. Giura, of the Rhode Island Medical Society Surgical Plan. After the discussion the Association voted to go on record endorsing as a group the report of the surgical insurance plan committee of the Rhode Island Medical Society, and further voted to so inform the Rhode Island Medical Society.

Respectfully submitted,

SAMUEL D. CLARK, M.D.
Secretary

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Secretary

KENT COUNTY

The October meeting of the Kent County Medical Society was held Tuesday, the fourteenth at 9 p.m. in Dr. Peter Erinakes' office. Fifteen members were present.

Beginning the evening, a film, "Continuous Spinal Analgesia in Caesarian Section", was shown by representatives of Abbott Laboratories.

Later, a discussion of the Surgical Plan sponsored by the Rhode Island Medical Society was presented by Dr. Rocco Abbate, chairman of the committee which developed this idea. All physicians present certified their willingness to participate in the plan as offered.

Dr. Robert Whitmarsh, chief surgeon at Roger Williams General Hospital, was guest speaker. Diagnosis and treatment of Gall Bladder disease were thoroughly outlined and the proper places of Medical and Surgical Management in this malady were elaborated.

This meeting was adjourned at 11 p.m.

Respectfully submitted,
FRANCIS D. LAMB, M.D.
Secretary

PAWTUCKET MEDICAL ASSOCIATION

The regular monthly meeting of the Pawtucket Medical Society was held October 23, 1947, in the Nurses' Auditorium of the Memorial Hospital. The meeting was called to order by the President, Dr. Earl Mara, at 9:00 p.m.

The Prepaid Surgical Plan was discussed in detail by Dr. Mara who suggested that all physicians give their approbation regardless of whether or not they were doing surgery.

The speaker of the evening was Dr. Robert L. Williams, Associate Pathologist of the Rhode Island Institute of Pathology who discussed "Clinical Application of Bone Marrow Biopsies." Dr. Williams illustrated his remarks with a fine series of micro-slides.

The meeting adjourned at 10:30 p.m.

Nineteen members attended.

Respectfully submitted
KIERAN W. HENNESSEY, M.D.
Secretary



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WOMAN'S AUXILIARY

THE FALL MEETING of the Woman's Auxiliary to the Rhode Island Medical Society was held on October 27, 1947, at the Rhode Island Medical Library.

The meeting was called to order at 10:30 a. m. by the President, Mrs. Herbert E. Harris.

The Secretary's report was read and approved.

The Treasurer reported a balance on hand of \$281.60.

Mrs. Bertram H. Buxton, Chairman of the Organization Committee, reported that her Committee had met. They recommended that membership cards be printed.

Mrs. Earl Mara, also on that Committee, inquired as to the possibility of having a membership list published in the RHODE ISLAND MEDICAL JOURNAL so that the various district chairmen would know who the paid members were in their district.

Reports from the Convention at Atlantic City in June were read by the Delegates, Mrs. Charles H. Ashworth and Mrs. Charles L. Farrell.

The President also read her report.

Mrs. Frederick H. Stevens of Bristol inquired as to the possibility of having Auxiliary meetings at night in conjunction with the Rhode Island Medical Society meetings. The President referred the matter to the Board of Directors for a decision.

Mrs. Stevens also asked for volunteers for the Children's Heart Clinic.

It was moved by Mrs. Bertram H. Buxton that greetings be sent to Mrs. Guy W. Wells, our Vice President, who is ill. Mrs. Frank Hanley seconded that motion. The motion was carried.

A motion to adjourn was made by Mrs. Paul C. Cook and seconded by Mrs. Joseph C. Johnston and was adopted.

The meeting adjourned at 11:15 a. m.

Following a business meeting a very interesting historical motion picture was shown by Chief Rosa of the United States Navy. This was in conjunction with Navy Day observance. The picture was entitled, "The Black Cat" and showed some of the activities of our fighting planes during the war.

The afternoon session was called to order at 2:00 p.m. by the President who then introduced Dr. Arthur H. Ruggles, President of the Rhode Island Medical Society.

Dr. Ruggles greeted us on behalf of the Medical Society. He then introduced the speaker of

the afternoon, Clair E. Turner Dr.P.H., former professor of Public Health at M.I.T., and now assistant to the President of the National Foundation for Infantile Paralysis.

The subject of Dr. Turner's address was, "Need for a State-Wide Health Education Program".

In his opening remarks, Dr. Turner paid tribute to Dr. Charles V. Chapin and expressed commendation of his achievements. He also spoke of the progress being made in education in Rhode Island.

Dr. Turner quoted from his recently published book, "Health Education and School Health" and drew comparisons between these subjects. He discussed four phases of Health Education:

- 1st: Direct health-hygiene instruction of children.
- 2nd: Industrial health—a planned day physically and mentally.
- 3rd: Healthy and properly trained teachers with sound relationship.
- 4th: Sound relationship between school health and community health.

Dr. Turner hopes that some day the common cold will be treated as a communicable disease. He also stressed the need for alert salaried men for constant supervision of restaurants.

The Woman's Auxiliary was gratified by the large attendance of Public Health nurses.

The meeting adjourned at 3:15 p. m.

Respectfully submitted

MRS. CHARLES L. FARRELL

Secretary

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**RHODE ISLAND REGIONAL COMMITTEE
ON FRACTURES OF AMERICAN
COLLEGE OF SURGEONS**

The annual executive meeting of the Rhode Island Regional Committee on Fractures of the American College of Surgeons was held at the Rhode Island Medical Library on November 5, 1947. Dr. Henry McCusker was re-elected chairman, and Dr. Robert T. Henry was re-elected secretary-treasurer.

The chairman spoke briefly about the clinical meeting of the New England Committee to be held in Boston on November 14, and then elaborated on the requirements of the state regional groups. The work of the various Rhode Island Regional sub-committees was then reviewed and satisfactory progress was noted. Dr. McCusker brought up for discussion the problem of rehabilitation of fracture patients in Rhode Island. He explained the growing interest in rehabilitation work which had proved so efficacious in the American Army hospitals. It was generally agreed that the present treatment of fractures was fairly acceptable and standardized but that late after-care in serious injuries was a pressing and important problem. After discussion of the problem by various members of the committee it was decided that a sub-committee should be formed to explore the need for a reconditioning center in this state.

The chairman appointed to this committee on Rehabilitation: Arthur E. Martin, M. D., Chairman; Herbert E. Harris, M.D.; Walter J. Molony, M. D.

The following sub-committees were also appointed to serve during the next year: Membership, Robert T. Henry, M. D., William A. Horan, M. D., Henry McCusker, M. D.; Clinical Meetings, Louis A. Sage, M. D., James C. Callahan, M. D., Walter J. Molony, M. D., Armand A. Bertini, M. D., James R. McKendry, M. D.; Hospital Care and Equipment, John Paul Jones, M. D., Augustine W. Eddy, M. D., S. G. Lenzner, M. D., S. S. Farago, M. D.; Relations with Other Organizations, Peter Pineo Chase, M. D., Kenneth G. Burton, M. D., Arthur E. Martin, M. D., William A. Stoops, M. D.

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AS IT LOOKS FROM NEW ENGLAND*

Wisconsin is but one of many state, area, or specialty medical societies. Its perspective is that of a midwestern state. But its problems, at least in part, are also problems elsewhere. These pages are provided periodically for the reactions of medical leadership in other parts of the country.



J. E. FARRELL

John E. Farrell, awarded an honorary Doctor of Science degree in June by Providence College as an outstanding executive officer and health educator, has been the executive secretary of the Providence Medical Association since 1938 and of the Rhode Island Medical Society since 1943. A fellow of the American Public Health Association, in 1945 he was instrumental in forming the Council of the New England State Medical Societies, of which he serves as executive secretary-treasurer.

Consider Wisconsin with more than five million additional residents, and then divided geographically into six separate states, each independent in thinking, planning, and government. Then you have in brief some idea of the size, population, and administration of the New England states as compared to Wisconsin.

New England is a distinct region, steeped in historic traditions and provincial in many of its attitudes. Yet it represents within its confines a kaleidoscopic view of all America. With five of its states having access to ocean waters, with three states marked by mountain peaks and large lakes, and with two states 60 per cent rural and the other four better than 60 per cent urban, New England permits a wide range of productive activities. Thus, for example, Rhode Island has the largest per capita industrial output of the nation; Vermont one of the highest ratios of dairy cows per capita.

Regional Consciousness Developed

With the many problems distinct to other sections of the country, industrial and agricultural, arising with the northeastern states, it is not surprising that the area has developed a regional consciousness that has resulted in a better understanding of issues common to all. And this same theory of regional thinking and planning has now been

* Reprinted from the July, 1947 issue of the *Wisconsin Medical Journal*. Copyrighted 1947—State Medical Society of Wisconsin.

extended to questions of medicine and health by the state medical societies.

In the summer of 1945 the Council of the New England State Medical Societies was organized at a meeting held in Providence, Rhode Island. Delegates from the six state medical societies in the region were in accord with the general principles which call for a

"closer cooperation between the state medical societies in New England in the development and the maintenance of the highest standards in the conduct and the administration of medical care, in the development of plans relative to the better organization of medicine, and in the furtherance of plans to improve the health of all the people in the New England States."

Proceedings of the Council

The council has sought to deal only with those major issues in which all the societies are concerned, recognizing that each society has its own peculiar problems that cannot be solved by any general provision. As a deliberative group the council seeks to educate the leaders of the various state medical societies, representing a medical population of approximately 14,000, on matters common to all, thereby bringing about a stronger unit in planning for organized medicine.

Thus, for example, the vexing question of medical licensure by endorsement was finally worked out through the cooperative effort of the council and the officers of the state medical examining boards. Now such endorsement is possible with all but Maine, where the statutes make such action illegal at present. Now a physician licensed in Connecticut, a graduate of a class A school, and able to meet all other educational and moral requirements of neighboring Rhode Island and Massachusetts, may qualify for licensure in those states by endorsement and without the necessity of passing written tests as required by the basic science and the medical examining boards of physicians making applications for initial licensure.

State Lines Overlooked

While state boundary lines may be vitally important to government officials, they mean little to the people of New England, particularly in the ques-

continued on page 903

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AS IT LOOKS FROM NEW ENGLAND

concluded from page 900

tion of medical and hospital care. Physicians in larger cities near neighboring states find many of their patients to be nonresidents. Thus, in Rhode Island we find patients coming to Pawtucket and Providence from nearby Massachusetts towns, and at the same time some Rhode Islanders going to Boston, 44 miles away, or, in the Newport County area, to nearby Fall River, 5 miles away, for hospitalization. The same situation exists in the other states, and New Hampshire and Vermont have even found it advantageous to have one hospitalization and one medical care program to encompass both states.

This situation has prompted the council to explore the provisions for extending medical care through voluntary insurance programs, and it is interesting to note the diversity of plans in such a compact region. All but Maine have passed enabling legislation to permit the formation of a non-profit corporation to provide prepaid surgical insurance. Massachusetts and New Hampshire have developed successful programs with the Blue Cross as the merchandising agent, and Vermont has now affiliated with the New Hampshire program. Connecticut and Rhode Island are completing studies calling for the utilization of private insurance carriers along the lines developed by Wisconsin.

Thus the area may become a testing ground to determine the comparable advantages and disadvantages of the two insurance programs for extending medical service on a voluntary basis. This diversity in thinking and planning in one compact area is certain to result in comparative studies in the future that will have important bearings on the development of plans in other parts of the country.

Accomplishments of the Council

The pattern of the Council of the New England State Medical Societies may well be copied by other areas to their advantage. The council has served successfully as an informative bureau for the officers of the state societies and as a discussion conference at which area problems receive careful and deliberative study. Within the past two years the council has explored such subjects as the medical needs of the veterans and of the physician veterans, medical public relations, industrial health, medical needs of rural communities, maternal and infant care, hospital survey, and the position of hospitals in the postwar world, medical licensure, group practice in the small community, and approaches to the national health question.

Certainly no region has taken more definite and progressive action in acquainting the officers of the state medical societies in its area with the attitudes, the decisions, and the plans of the medical profession in the neighboring states than has New England.—JOHN E. FARRELL

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